Testimony of

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and
HBMA Board of Directors

Chairman of their Government Relations Committee

Before The

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Mr. Chairman and Members of the Labor-HHS Subcommittee. On behalf of the Healthcare Billing and Management Association (HBMA), I appreciate this opportunity to testify today.

Founded in 19921993, HBMA is the only trade association representing third-party medical billing companies. billers. Our members process physician and other providers' claims integral to the health care delivery system.

HBMA members typically provide services to specialty physician groups and primary care practices and process Medicare, Medicaid, and private health insurance claims. A typical HBMA member processes approximately 20,000 claims per month, totaling $20 million per year, but ; some of our larger members bill millions of claims and billions of dollars per year.do much more.

Because of the nature of the work we do, billing companies interact with the Medicare program on a daily basis. But we interact on the business side of the Medicare program. Our dealings are often with those entities with whom the government contracts to do claims processing: Carriers, Intermediaries, etc.

As an industry, we are very concerned about what we are seeing in terms of the government being a reliable business partner. Excessive delays in the processing of claims and provider enrollment applications, failure of carriers to implement changes in a timely fashion and the imposition of costly requirements that delay payments to physicians and do serious financial harm to medical practices throughout the United States.

Mr. Chairman, Medicare is often the single largest payer in terms of a percentage of a medical practice's revenue of any third party payer. Consequently if Medicare is slow in processing claims or slow in issuing a new provider number, the financial consequences on a medical practice can be devastating.

While much of Congress' time over the past few years has been spent debating the prescription drug benefit, we have seen a serious erosion within the program when it comes to the processing of claims and information in a timely fashion.

Mr. Chairman, having a great prescription drug benefit is of little value to patients if there are not providers to write those prescriptions. If congress fails to put pressure on CMS and more importantly, it's contractors, to address the serious administrative problems, physician's will be forced to close their doors, not just for Medicare patients, but the entire community.

While we anxiously await the contractor reform that is currently underway within CMS, we are concerned that this will be little more than rearranging the deck chairs on the Titanic. Unless CMS provides aggressive oversight of the contractors, the same problems we are going to identify in our testimony today, we continue to exist in the future. It is not enough to just

periodically change contractors, it is making sure that those contractors do their job, have the staff necessary to do their job and do their job correctly!

In preparation for this testimony, we surveyed more than 600 billing companies from around the U.S. And here are some of the things we uncovered. I want to note that if we have identified something here, it was not a random observation by a single company but rather something that we have identified as occurring in multiple locations and therefore rises to, we believe, a systemic problem.

1. Customer service training – There are serious and recurring problems in the Medicare customer service centers. We are not the only ones who have noted serious problems in the Medicare call centers. In 2002, GAO reported that the Centers for Medicare & Medicaid Services (CMS) needed to improve its communications with providers who deliver medical care to beneficiaries. GAO reported that 85 percent of the responses it received to 61 calls made to call centers operated by Medicare carriers—contractors that help manage the Medicare program—were incorrect or incomplete. GAO also found that CMS's primary oversight tools were insufficient to ensure accuracy in communication.

In 2004, GAO went back to see if the improvements had been made and here's what they found, Mr. Chairman. Only 4 percent of the responses GAO received in 300 test calls to 34 call centers were correct and complete. GAO posed four policy-oriented questions 75 times each to carrier call centers. The level of correct and complete responses for each individual billing question ranged from 1 to 5 percent. The majority of remaining responses were incorrect, or partially correct or incomplete.

These findings are consistent with the experience of our members when they contact the call centers seeking clarification on a billing question. Billing companies report that their staffs are so distrustful of the information they receive that they have simply stopped calling, or spend inordinate amounts of time verifying the information they receive from the call center. Unfortunately, when we rely on the information we receive, submit claims based upon that information, and have the claim rejected – this causes serious financial hardship for the physicians. Mr. Chairman, depending upon the specialty, the value of the Medicare claims being delayed on a weekly or monthly basis can be in the tens of thousands of dollars. Like most businesses, physicians have employee costs and overhead they have to meet and they cannot afford to be out tens of thousands of dollars in money owed to them by the government and still meet their financial obligations.

By the way, our confidence in the ability of the Medicare Advantage Plans to get it right the first time is no greater. Remember that we have had experience with many of the MA Plans because they have commercial insurance products that our physicians bill to. The error rate and claims delays are every bit as bad, if not worse, in the commercial insurance industry.

2. As you may know, Mr. Chairman, CMS recently changed their standards to require the name submitted on the medical claim match **exactly** the name on a beneficiary's Social Security card**.** If the patients middle initial, for example, is S, as in Harry S Truman, and you put a period, the system will reject the claim. If the patient goes by a hyphenated last name, such as

Rodham-Clinton, but the Social Security Card just says Clinton or Rodham, the claim will be rejected. If the claim uses an abbreviation of the first name, such as Tim instead of Timothy or Bob instead of Robert, the claim will be rejected. Even if the claim has the correct Social Security number.

Most hospital-based physicians (emergency, pathology, radiology and anesthesiology), must rely upon the hospital to collect the accurate information and pass this along. And even when the hospital thinks the information has been correctly entered into the system because that' s what the patient said, sometimes the patients are wrong. Sometimes they forget how or even if they changed the information on their Social Security card when the got married.

This has caused many rejections for claims submitted by the hospital-based physicians who are typically unable to obtain a copy of the card. This caused additional expense in tracking down the correct information from the referring physician or the patient (at great frustration for the referring physician office staff and patients). Additionally, costly programming changes had to be made to allow for longer names and names that have an initial as the first name, such as C.W. Bill Young.

At times, Mr. Chairman, there seems to be little time spent working with the industry on simple things that could avoid major problems. If there was just better communication between payers and providers, so many things could be handled more efficiently, more effectively and more accurately.

The nature of the work we do and the volume of claims we handle causes our member companies to interact with the Medicare program every day. Our dealings are with the companies with whom the government contracts to do claims processing – Carriers, Intermediaries, DMERCs, etc., – as well as directly with the Medicare program's web site, CMS' Regional Offices and CMS' National staff.

3. Many billing companies are finding that there still is not universal compliance with the HIPAA transaction standards. The Health Insurance Portability and Accountability Act or HIPAA was intended to create administrative simplification and more uniformity in the claims processing arena. While there have been improvements, Mr. Chairman, I am here to tell you that we are not even close to achieving the types of improvements that could have been achieved .

As an industry that makes its living dealing with the Medicare and Medicaid programs, we are very concerned by what we see in terms of government programs being unreliable business partners. Every day we see avoidable and excessive delays in claim processing; poor use of 21st century computer technology; an archaic approach to enrolling doctors as Medicare providers; poorly trained customer service staff(s) that provides inaccurate instruction to the medical community; failure of carriers to reliably or consistently interpret and implement published changes; and imposing requirements that delay payments and add costs to our physicians. Often these changes do serious financial harm to America's medical practices, and erroneously place providers in harm's way with respect to fraud and abuse laws.

HHS only recently adopted the uniform standards for claims submissions and the proposed standards for claims attachments (i.e. X-rays, physician notes, etc.) Were only recently submitted to the public for comment. The agency does not expect to have these in place for several more years! Mr. Chairman, HIPAA was passed more than 10 years ago.

Mr. Chairman, Medicare is often a practice's single largest payer. Consequently, if Medicare is slow in processing claims or slow in issuing a new provider number, the financial consequences on a medical practice can be, and often are, devastating. HBMA's members encounter new examples of problems every month, often demonstrating CMS' ignorance of the day-to-day operations of medical practices and the mechanics of medical billing which results in CMS's poor planning and implementation. While much of Congress' time over the past few years has been spent debating the prescription drug benefit, we have seen a serious lack of attention to and the resulting erosion of the program when it comes to the timely processing of claims and information.

Mr. Chairman, having a great prescription drug benefit is of little value to patients if there are not providers to write those prescriptions. If congress fails to obligate and support CMS, and more importantly, it's contractors, to address many serious administrative problems, physicians may be forced to close their doors, not just for Medicare patients, but for the entire community. Already, some are reducing or even eliminating Medicare beneficiaries from their practice. Quite frankly, the economic burdens, increased administrative burdens and significant risk of unintentional fraud and abuse to the program are creating an industry climate that is reaching a boiling point.

While we anxiously await the contractor reform that is currently under way within CMS, we are concerned that this will be little more than rearranging the deck chairs on the Titanic. Unless CMS provides more aggressive oversight of contractors, the same problems we are going to identify in our testimony today will continue to exist in the future. It is not enough to change contractors, it is making sure that those contractors do their job; and have the staff and education necessary to do their job and do their job correctly!

Even with the mandate for uniform claims processing standards, individual insurance companies can still require unique information or that information be located in different boxes on the forms. While the computer language has been standardized, we still function in a world of individual claim forms that are time-consuming to complete and result in unnecessary delays. Compare what we experience in the health care arena to what has become almost standard in other sectors of the business world.

The next time you go to a gas station or convenience store, instead of using cash, look at all of the various methods you have to electronically move money from your account to the gas company or convenience store's account. In most cases, before you even leave the store or the station, the money will have been deposited in the company's account and a detailed description,

including items, date and time, will be recorded for later review. Furthermore, computers can not only tell you where you bought the product you purchased, it can tell you the distributor from whom the store bought the product and where it was manufactured! If you really pushed the system, it could probably tell you who worked that day on the assembly line of the manufacturer and who inspected the item before it left the factory.

In healthcare, not only does the insurance company seem confused by information telling them what happened during the visit with the doctor, but it takes up to 30 days for the money to be moved from the insurance company's account to the physician's account. And, it can often requier the use of paper to either verify the transaction or substantiate what has occurred.

In preparation for this testimony, we surveyed more than 600 billing companies from around the U.S. representing all medical specialties, thousands of physicians and thousands of U.S. based employees. And hereAs an industry, we applauded the HIPAA mandates. Unfortunately, the promises of HIPAA have been just that, promises. Some of our member companies report that they are less automated today, more than 10 years after HIPAA, then they were before HIPAA was passed.

Here are some of the things we uncovered. Please note that if we have identified something here, it was not a random observation by a single company, but rather something that additional concerns we have identified as occurring in multiple locations and therefore constitutes, we believe, a systemic problem.heard from HBMA member companies over the past several months:

HIPAA Transaction Standardization Must Be Completed. Many billing companies are finding that there still is not universal compliance with the HIPAA transaction standards. The Health Insurance Portability and Accountability Act, or HIPAA, was intended to create administrative simplification and more uniformity in the claims processing arena. While there has been some progress, Mr. Chairman, I am here to tell you that we are not even close to achieving the types of improvements that were promised or could be achieved. A. Medicare in Florida will not tell providers what MA plan a beneficiary has enrolled in even though the patient has told the practice that they are in a Medicare HMO plan but cannot find their card.

HHS only recently adopted the uniform standards for claims submissions. The proposed standards for claims attachments (i.e. X-rays, physician notes, etc.) were only recently submitted to the public for comment. The agency does not expect to have these in place for several more years! Mr. Chairman, HIPAA was passed almost 10 years ago.

Even with the mandate for uniform claims processing standards, individual insurance companies ignore HIPAA' mandate and require unique information or that information be located in different places on the forms. While the computer language has been standardized, we still function in a world of individual claim forms that are time-consuming to complete and result in unnecessary delays. Compare what we experience in the health care arena to what has become almost standard in other sectors of the business world.

The next time you go to a gas station or convenience store, instead of using cash, look at all of the various methods you have to electronically move money from your account to the gas company or convenience store's account. In most cases, before you even leave the store or the station, the money will have been deposited in the company's account and a detailed description, including items, date and time, will be recorded for later review. Furthermore, computers can not only tell you where you bought the product you purchased, it can tell you the distributor from whom the store bought the product and where it was manufactured! If you really pushed the system, it could probably tell you who worked that day on the assembly line of the manufacturer and who inspected the item before it left the factory.

In healthcare, not only do insurance companies seem confused by information telling them what happened during the visit with the doctor, but it takes up to 30 days for the money to be moved from the insurance company's account to the physician's account. And, it can often require the use of paper to either verify the transaction or substantiate what has occurred. B. Standardized the Explanation of Benefits (EOB) electronic format for all commercial payors. Adoption of what is referred to as the HCFA 1500 was an efficiency bonanza for the payors.

This freed them from deciphering claims submitted in an unlimited variety of formats from a vast array of providers. Economies of scale were achieved at the payer level that resulted in the elimination of thousands of jobs and resulted in untold savings to the insurance industry.

Unfortunately, the same type of standardization has not occurred with respect to how third party payers communicate with providers. The amount of time and money wasted at the poster and collector level across the industry due to conflicting, inconsistent, incomplete, confusing and undecipherable EOB formats is staggering. Lack of standardization is an impediment to implementation of electronic remittance and automated posting.

C. One Regional Carrier for Durable Medical Equipment (DMERC) takes 21 days to establish an electronic link when the supplier attempts to add link for a new provider. Most DMERCs accomplish this task in 1 – 2 days.

D. Allow for on-line, real-time enrollment. Why can't we, at a minimum, have on-line provider enrollment. Currently, we must go online, fill out the forms, then print the form and submit the form through regular mail. The technology exists. The IRS has it, states have it, why can't CMS use the same technology?

As an industry, we applauded the HIPAA mandates. Unfortunately, the promises of HIPAA have been just that – promises. Some of our member companies report that they are less automated today, more than 10 years after HIPAA, than they were before HIPAA was passed. We strongly encourage CMS to keep HIPAA Transaction Set Standardization a high priority with their contractors, and enforce these standards across the private payor sector of the industry. We strongly encourage this committee to make the appropriate resources available to CMS to complete this necessary work.

E. Allow the submission of transactions over the Internet. Almost all commercial payers use the Internet and accept claims via FTP. Medicare is still using old dial-up technology. The transfer rates are very slow and we have continual problems with lines dropping during transmission. They need to adopt current technology.

F. Provide a secure, on-line inquiry system to verify and obtain the National Provider Identifier (NPI). Unless CMS provides broader access to verify NPI numbers, billing companies and others will have to get the numbers from the doctors. While this may not seem like a difficult task, consider that it is often necessary to obtain the NPI for the referring physician who is not only in a different practice, but often a different town or state! If we were able to do an on-line verification, we could let the physicians do what they do best – treat patients - and not have to take their valuable time verifying information that could be more readily available technologically.

Customer service training. There are serious and recurring problems in the Medicare customer service centers. We are not the only ones who have noted serious problems in the Medicare call centers. In 2002, GAO reported that the Centers for Medicare & Medicaid Services (CMS) needed to improve its communications with providers who deliver medical care to beneficiaries. GAO reported that 85 percent of the responses it received to 61 calls made to call centers operated by Medicare carriers—contractors that help manage the Medicare program—were incorrect or incomplete. GAO also found that CMS's primary oversight tools were insufficient to ensure accuracy in communication.

Mr. Chairman, I don't want to leave you with the impression that the staff at CMS are unresponsive or uncooperative, that would be a disservice to them.

In 2004, GAO went back to see if the improvements had been made and here's what they found, Mr. Chairman. Only 4 percent of the responses GAO received in 300 test calls to 34 call centers were correct and complete. GAO posed four policy-oriented questions 75 times each to carrier call centers. The level of correct and complete responses for each individual billing question ranged from 1 to 5 percent.For the most part, we have found the CMS staff to be most cooperative and willing to meet with us or provide speakers to help us, educate our members. The problem is not with the personnel at CMS. The majority of remaining responses were

incorrect, or partially correct or incomplete. Incidentally, the questions used by the GAO were taken from the FAQs on the Carrier's own web site!problem, Mr. Chairman, is a lack of resources to hire the staff necessary to handle the issues we've identified. I can't tell you how many times we've been told over the past two years that staff have been temporarily reassigned to handle a Medicare part D implementation issue. CMS needs more staff. Recently, as staff person for an HBMA member company was told – off the record, of course – that there was a hiring freeze for both internal AND external personnel. If this is true, this means that not only is CMS prohibited from replacing long-time employees who are retiring, the contractors are also prohibited from hiring new staff as well. The fall-out from such a hiring freeze could be disastrous.

These findings are consistent with the experience of our members when they contact the call centers seeking clarification on a billing question. Billing companies report that their staffs are so distrustful of the information they receive that they have simply stopped calling, or spend inordinate amounts of time verifying the information they receive from the call center. Unfortunately, when we rely on the information we receive, submit claims based upon that information, and have the claim rejected – this causes serious financial hardship for the physicians. Mr. Chairman, depending upon the specialty, the value of the Medicare claims being delayed on a weekly or monthly basis can be in the tens of thousands of dollars. Like most businesses, physicians have employee costs and overhead they have to meet and they cannot afford to wait for tens of thousands of dollars owed to them by the government for already-rendered services and still meet their financial obligations.

By the way, our confidence in the ability of the Medicare Advantage Plans to get it right the first time is no greater. Remember that we have had experience with many of the MA Plans because they have commercial insurance products that our physicians bill. The error rate and claims delays are every bit as bad, if not worse, in the commercial insurance industry.

Planning, Testing and Communication. At times, Mr. Chairman, there seems to be little time spent working with the industry on simple things that could avoid major problems. If there was just better communication between payers and providers, so many things could be handled more efficiently, more effectively and more accurately. Following are a few examples:

CMS recently changed their standards to require that the name submitted on medical claim match **exactly** the name on a beneficiary's Social Security card**.** If the patients middle initial, for example, is S, as in Harry S Truman, and you put a period, the system will reject the claim.

CMS also needs more authority to force the insurance industry to adopt the HIPAA transaction standards. We recognize, Mr. Chairman that the appropriations Committee and your Subcommittee does not have policy jurisdiction over either CMS or the HIPAA enforcement process. But you can hold oversight hearings to see how the money you appropriate to CMS for program administration and HHS for HIPAA enforcement is being spent

If you and your subcommittee are able to do anything, Mr. Chairman, we urge you to conduct an oversight hearing and look into the concerns about Medicare program administration and HIPAA enforcement that we have raised.

There is no reason that claims processing has to be so cumbersome and archaic. The technology exists in the banking industry to protect the privacy of individuals yet allow electronic transactions. Why are we trying to reinvent the wheel for health care. The technology exists that allows all of us to have cell phones produced by different manufacturers and serviced by different phone companies and yet we are able to talk to one another.

Most hospital-based physicians (emergency, pathology, radiology and anesthesiology), must rely upon the hospital to collect the accurate information and pass this along. And even when the hospital thinks the information has been correctly entered into the system based on what the patient provided during the admitting process, sometimes the patients are wrong. Sometimes they forget how or even if they changed the information on their Social Security card when they got married.

This has caused many rejections for claims submitted by the hospital-based physicians who are typically unable to obtain a copy of the card. This caused additional expense in tracking down the correct information from the referring physician or the patient (at great frustration for the referring physician office staff and patients).

National Provider Identifier (NPI) – CMS is implementing the NPI portion of HIPAA legislation, however, as it currently stands, CMS will NOT make NPI information publicly available as they do with the current UPIN number. Because this number is required for billing purposes, non-publication of this number will negatively impact specialist physicians that must include the referring physician's identification number in order to receive payment for properly rendered services. If this policy stands, it will temporarily halt specialist physician cash flow until the numbers can be manually obtained one-by-one. This is prohibitively expensive and painful to both referring and specialist physicians. We hope that this will be carefully considered and that the system be thoroughly tested prior to national roll-out.

Program accessibility. The internet has revolutionized many aspects of our society and has provided many useful improvements in making federal programs more accessible and understandable for those with computers. However, since 2004, the CMS web site, which was previously highly navigable and easily searched, has become nearly impenetrable! A highly touted "overhaul" has rendered many of the answers, regulations, forms and references that are essential for providers and billing companies to understand nearly impossible to find. Even our most experienced members, their consultants and lawyers lament the demise of a formerly useful means of accessing information.

Mr. Chairman, on behalf of the third party billing industry, we appreciate this opportunity to share our views with you on these important issues.

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